MASSACHUSETTS TIERED NETWORK MEMBERSHIP

CHIA's *2015 Annual Report on the Performance of the Massachusetts Health Care System* profiled overall membership and cost trends in the Massachusetts market from 2012 to 2014. This brief provides additional coverage and cost details on tiered network membership in the Commonwealth.[1]

TIERED NETWORKS IN MASSACHUSETTS

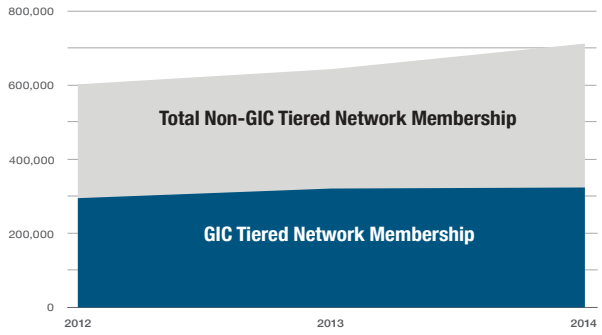
Tiered network health plan adoption has been a high priority for Massachusetts plans and policymakers seeking health care cost savings.[2] Under tiered network plans, payers "tier" service providers by quality and/or cost-efficiency measures and hold members responsible for paying higher levels of cost-sharing for utilizing providers in lower-rated tiers.[3] This out-of-pocket price variation is designed to encourage members to choose lower cost or higher quality providers, potentially resulting in lower overall health system expenditures and improved patient outcomes.[4,5] Influencing provider behavior may also be a primary goal.[6] Not all tiering products are the same; they may vary based on which providers are tiered, the tiering methodology, and the range of copayments faced by members.[7] Early research on the impact of tiered networks remains mixed.[8] Tiered network results in isolation should also be viewed with caution, as other unaccounted for confounding factors may skew results.[9]

Massachusetts's Group Insurance Commission (GIC) has led payer development and adoption of tiered provider networks in the Commonwealth. (For more detail on the GIC's definition of tiered networks see *Understanding the GIC Membership*.) Since 2007, the GIC has required that all commercial plans offered to its more than 250,000 state and municipal employees have at least specialist provider-tiering.[10] In 2010, as part of Massachusetts's Chapter 288 health care reforms, the Legislature supported broader commercial tiered network plan development by requiring that all insurers offering closed network plans in the merged market also offer "at least one plan with either a reduced or selective network of providers, or a plan in which providers are tiered."[11] Tiered plans were to have premiums at least 14% lower than that of an actuarially similar plan with the payer's full provider network.

TIERED NETWORK MEMBERSHIP GROWS BEYOND THE GIC

In 2014, approximately 712,000 Massachusetts commercial market members—16% of the market—were enrolled in a tiered network plan.[12]

1 Massachusetts Tiered Network Membership (2012-2014)



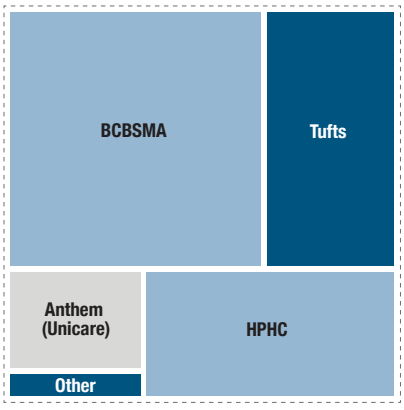
Tiered Network Membership	2012	2013	2014	Change (2013-2014) Number	Change (2013-2014) Percentage
GIC*	284,849	306,988	311,185	4,197	1%
Non-GIC (Derived)	318,472	336,890	400,634	63,744	19%
Total	603,321	643,878	711,819	67,941	11%

Sources: CHIA payer-reported data, calendar year (CY) totals; GIC Annual Report membership fiscal year (FY) totals; non-GIC membership estimates from FY and CY data; GIC totals exclude Fallon Select membership.

Notes: Based on MA contract membership, which may include non-MA residents.

*The GIC network plans may not consider all members as tiered. See "Understanding the GIC Membership."

2 Massachusetts Tiered Network Membership by Payer



MA Tiered Network Membership: 711,819 (+11%)

Source: CHIA payer-reported data; GIC Annual Reports

Notes: Based on MA contract membership, which may include non-MA residents. "Other" payers include Aetna, Fallon, HNE, and NHP.

More than forty percent (311,000) were insured through the GIC. (See *Understanding the GIC Membership*.)[13,14] Of the remainder, three-in-five were covered by Blue Cross Blue Shield of Massachusetts (BCBSMA), the state's largest payer and largest tiered network administrator.

Tiered network membership growth has been steady in Massachusetts. Tiered network membership increased by 11% (+68,000 members) since 2013, and 18% (+108,000 members) since 2012, as overall market membership remained flat. **(Figure 1)** Growth has been largely concentrated outside of the GIC, as both local and national payers have expanded—and encouraged the adoption of—their tiered network offerings.[15,16] Tufts Health Plan was the largest contributor to non-GIC tiered membership growth between 2013 and 2014, adding over 35,000 net new members to its rolls.[17] **(Figure 2)**

FULLY-INSURED TIERED NETWORK MEMBERS HAVE LOWER PREMIUMS BUT HIGHER COST-SHARING

In 2014, fully-insured tiered network plan members paid average premiums of $423 per member per month (PMPM), 3.2% less than non-tiered network plan members.[18] This difference increased to 10.5% after accounting for member, group, and plan benefit factors.[19] From 2013 to 2014, premiums for tiered network members increased by 1.0%, below non-tiered premium growth (1.7%).

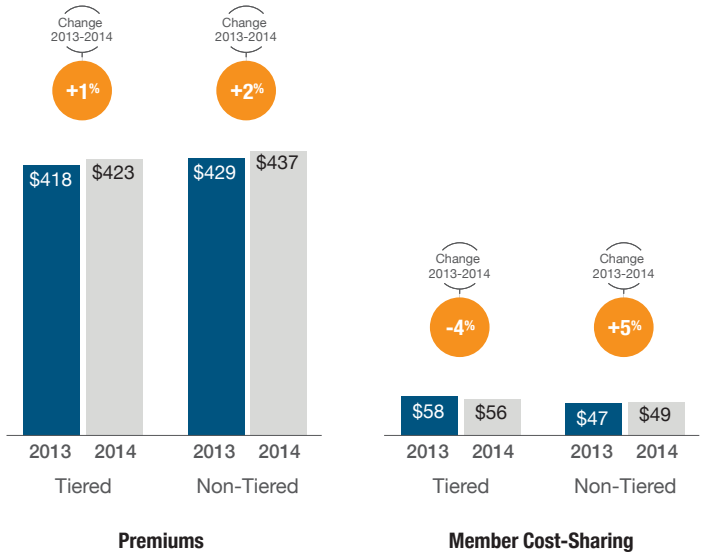
Tiered network members, however, paid 12% more than non-tiered network members in cost-sharing ($56 PMPM and $49 PMPM). Nearly all payers reported though that average tiered network cost-sharing remained steady or declined from 2013 to 2014, possibly as members migrated to lower-cost tiers and/or cut back on higher cost-sharing services.[20] Fully-insured tiered network member cost-sharing declined by 4.3% as non-tiered cost-sharing increased by 5.1%. **(Figure 3)**

SELF-INSURED TIERED NETWORK MEMBERS HAVE HIGHER PREMIUM-EQUIVALENTS BUT LOWER COST-SHARING

More than two-thirds (68%) of Massachusetts tiered network membership was self-insured in 2014, with more than half of those members covered by the GIC.

In 2014, self-insured tiered network premium-equivalents—medical costs paid by employers for their employees' and employee dependents' medical care—were 10% higher than non-tiered premium-equivalents ($490 PMPM and $445 PMPM, respectively), and increased faster than

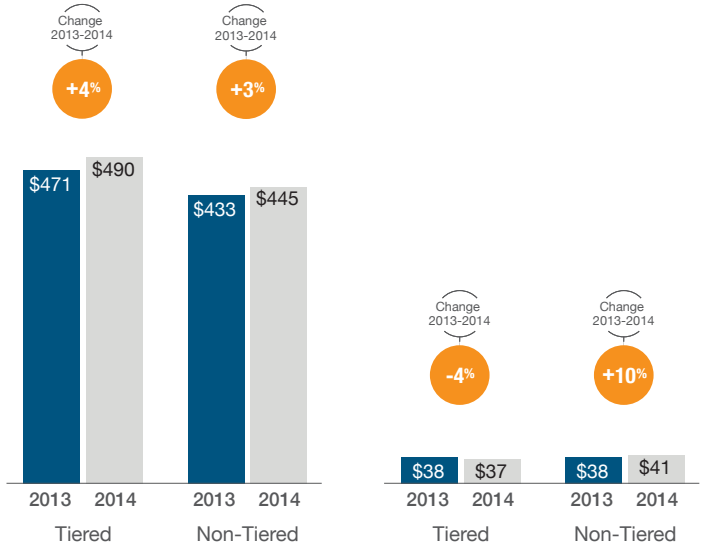
3 Massachusetts Fully-Insured Tiered Network Premiums & Cost-Sharing (2013-2014)



Source: CHIA payer-reported data

Notes: Based on MA contract membership, which may include non-MA residents.

4 Massachusetts Self-Insured Tiered Network Premiums & Cost-Sharing (2013-2014)



Source: CHIA payer-reported data

Notes: Based on MA contract membership, which may include non-MA residents. Self-insured data for CIGNA and United excluded.

non-tiered premium-equivalents over the prior year (+4.0% and +2.9%, respectively).[21] The GIC population, which, on average, has higher member medical claims and receives more generous benefits than the average commercial enrollee, may have contributed to the higher observed tiered network medical costs in this part of the market.[22] Results here may not reflect the effectiveness of tiering on cost control within the GIC; CHIA will be reviewing GIC data in the coming year.

Self-insured tiered network members had lower average cost-sharing than non-tiered members in 2014 ($37 vs. $41 PMPM). As in the fully-insured market, self-insured tiered network member cost-sharing also declined over time: tiered member cost-sharing decreased by 3.6% from 2013 to 2014, as non-tiered member cost-sharing increased by 9.7%. **(Figure 4)**

For questions on this brief, please contact Kevin Meives, Senior Health System Policy Analyst, at (617) 701-8208 or at Kevin.Meives@state.ma.us.

Understanding the GIC Membership

The Group Insurance Commission (GIC) was established by the Legislature in 1955 to provide and administer health insurance and other benefits to the Commonwealth's employees and retirees and their dependents and survivors.[23] In 2004, the GIC launched its Clinical Performance Improvement Initiative (CPII), where, with Mercer, it analyzed its member claims data to categorize physicians by quality and efficiency measures.[24] GIC health plans were then required to use results to tier specialists, assigning members lower copays for selecting the "highest performing quality and/or cost efficient doctors."[25] The CPII created new incentives for members, to select the most efficient providers, and for providers, to examine their practice patterns and challenge their current usage of resources.

Most of the GIC's membership has been classified in this brief as being part of a "tiered network,"[26] although the GIC does not consider all of these members to be in a tiered network plan.

Notes

1 Contract member data provided by 11 Massachusetts commercial payers. For CHIA tiered network definition and additional data source information, see technical appendix.

2 According to the Health Policy Commission's (HPC) 2014 Annual Report, the "take-up of… [tiered] network plans has remained relatively low, but the enrollment patterns in some markets (Group Insurance Commission, the Connector) suggest that consumers do choose low-cost plans when presented with choice, incentives, and comparative information. The greatest near-term opportunity for demand-driven cost containment may reside in enhancing the availability and take-up of value-oriented products in the employer market." (Page 8) Massachusetts's Office of the Attorney General also noted in its 2015 Annual Report that "tiered network products [continue to] hold promise" for cost containment, with a "recent study of members in BCBS's tiered products [finding an association]… with higher use of better value hospitals compared to members enrolled in non-tiered products." (Pages 7, 9)

3 CHIA's payer-approved tiered network definition is based on Massachusetts Division of Insurance regulation 211 CMR 152.00, *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. 211 CMS 152.00 defines a "Tiered Provider Network" as one "in which a Carrier assigns Providers to different benefit tiers based on the Carrier's assessment of a Provider's relative cost and, where available, quality and in which Insureds pay the cost-sharing (copayment, coinsurance or deductible) associated with a Provider's assigned benefit tiers." See technical appendix.

4 The 2014 Kaiser/HRET Employer Health Benefits Survey reported that 54% of firms offering health benefits considered tiered provider networks to be "very" or "somewhat" effective at containing health insurance costs.

5 According to the HPC's 2014 Annual Report, "innovative network strategies [including tiered networks] aim to lower spending by directing patients to lower cost, high quality providers, and, ultimately, to encourage higher cost providers to lower their prices to seek to obtain more favorable placement. In New Hampshire, these strategies have resulted in significant cost savings to individuals at the point of service…and ultimately, reductions in premiums. In Massachusetts, these strategies could lead more patients to seek care at their local community hospitals, for example, rather than travel to higher-priced academic medical centers." (Page 62)

6 For example, the GIC's stated primary focus of its "differential co-payment" Clinical Performance Initiative, is not "exclusively or even primarily on cost control…[rather, it is] focused on provider behavior …[getting] physicians, particularly more expensive specialists, to examine their practice patterns and resource usage." (GIC - private correspondence, January 6, 2016.)

7 As noted in Attorney General's 2015 Cost Trends report: "The design of tiered products includes three main elements: (1) the scope of services and providers tiered, (2) the size and type of cost sharing differentials across tiers (e.g. how much copayments vary)… and (3) the methodology used to tier providers…[In Massachusetts] it is an open question whether the size and timing of [cost] differentials, coupled with potentially fragmented approached to which services are or are not subject to tiering…runs the risk of confusing customers and diffusing the product's effectiveness."

8 Anna Sinaiko and Meredith Rosenthal in their American Journal of Managed Care paper, "Consumer Experience with a Tiered Physician Network: Early Evidence," found that "although the majority of consumers who were aware of the tiered networks also knew that they were constructed using both cost and quality measures, few respondents trusted the tiers to identify better doctors. Trusted sources of information for selecting a physician included their own physician, physician professional societies, and independent consumer groups; health plans and employers were the least trusted sources for this information." Sinaiko and Rosenthal's follow-up paper, "The Impact of Tiered Physician Networks on Patient Choices," continued to find tiered-patient-to-physician stickiness ("significant loyalty to physicians"), though also found that "tiered networks did…appear to impact physician market share through the channeling of new patient visits away from the lowest tiered physicians…Even if the magnitude of [the] market share shift caused by tiered networks is modest, the threat of long-term market share loss is likely to be a significant force for motivating providers." Frank, Hau, Landrum, and Chernew, in their Health Services Research paper, "The Impact of a Tiered Network on Hospital Choice," however, identified that Blue Cross Blue Shield of Massachusetts' tiered network—with high non-emergency, hospital, cost-sharing differentials categorized on quality and cost-efficiency measures—was "able to steer patients toward preferred hospitals while preserving a greater degree of provider choice." They found that "a 10 percent increase in cost-sharing difference cause[d] a 1.3 percent shift in scheduled admissions from non-preferred to preferred/middle hospitals."

9 For example, correlated benefit types and plan self-selection may influence unadjusted results.

10 According to its FY2006 Annual Report, the GIC's Clinical Performance Improvement Initiative (CPII) started with its Fiscal Year 2004 health plan procurements. The GIC, along with its consultant, Mercer, analyzed over 120 million member claims then provided provider performance data to payers to inform their network design strategies. Payer-established tiered networks were not always congruent, and largely tiered for specialists. In 2007, the GIC's tiered network referrals were profiled in Managed Care. In recent years, the GIC has also pushed payers to add limited network options to some tiered offerings.

11 See Chapter 288, Section 32: Establishing Selective and Tiered Networks

12 By CHIA's definition and payers' assessment of their membership. See technical appendix.

Notes (continued)

[13] Estimated GIC membership proportion derived using the GIC FY2014 enrollment counts from the GIC FY2014 Annual Report and payer-reported full-market data from the CY2014 CHIA Annual Premiums Data Request. Calendar year and fiscal year differences may affect this estimate.

[14] Approximately 87% of GIC members were enrolled with Tufts Health Plan, Harvard Pilgrim Health Care (HPHC), or Anthem (Unicare); Fallon, Health New England, and Neighborhood Health Plan enrollees accounted for the remainder. Most GIC members were covered under self-insured plans. Several GIC plans include retirees not yet eligible for Medicare.

[15] According to 2015 HPC Payer Testimonies, Aetna, CIGNA, and United Healthcare have all recently introduced, or are planning to introduce, new tiered network products in Massachusetts. HPHC noted that it continues to design and revise their limited and tiered network products "to encourage members to seek care from high-value providers." HPHC offers non-GIC employers Tiered ChoiceNet, Hospital Prefer, and Focus Network products. BCBS offers employers Tiered HMO and Preferred Blue Options and Hospital Choice Cost-Sharing Options products. Tufts Health Plan offers non-GIC employers Tiered Your Choice and Select Network products. For a more comprehensive inventory of current fully-insured health benefit plans, please see Massachusetts Division of Insurance's regular listing.

[16] Unlike most other payers, Fallon Health's tiered network assessment in its HPC Testimony was more reserved: "Fallon Health has been a leader in developing limited and tiered network products that encourage the use of high-quality, low cost providers. These products have continued to grow and now represent 50% of our commercial membership…[However,] the Massachusetts legislative framework has…prevented us from expanding our tiered products. Chapter 288, which was intended to stimulate the growth of tiered networks, includes an unfortunate provision that enables providers to opt out of any products in which they are not favorably tiered, regardless of their quality or cost. This has effectively enabled our large and increasingly consolidating provider systems to block expansion of tiered products." (Page 5)

[17] Tufts's overall tiered network membership grew by 25% (+37,000 members) between CY2013 and CY2014. Non-GIC growth estimate (+35,000, +65%) derived using FY2013 and FY2014 GIC Annual Report data.

[18] Results in this brief are scaled to full benefits and net of medical loss ratio rebates, unless otherwise noted.

[19] See technical appendix for adjustment methods.

[20] Tiered network member allowed amounts were flat (+0%) from 2013 to 2014, while non-tiered members' allowed amounts increased by 2.4%. This may indicate lower member service utilization and/or higher member utilization of providers with which payers have more favorable negotiated rates.

[21] The cost of fully-insured coverage is measured by the annual premium an employer pays to a commercial payer to assume the risk of eligible employees' and employee-dependents' medical expenses. The cost of self-insured coverage is measured by the annual premium-equivalent, the sum of two components: the amount an employer pays providers annually for the medical costs of its employees and employee-dependents; and the amount an employer agrees to pay a payer or third party administrator to design its plans, administer its claims, and/or utilize its network of negotiated provider rates.

[22] Based on available data where the GIC population could be isolated. Self-insured tiered network plans had an average actuarial value of 0.944, compared to 0.925 for the overall self-insured market. This relationship between network tiering and actuarial values was reversed among fully-insured plans. Self-insured tiered network members were also older than non-tiered members (26% were 55 years or older, compared to 19% of non-tiered self-insured members). These factors may have contributed to the higher medical costs observed: members of self-insured tiered network plans had, on average, $506 PMPM in allowed claims, compared to $464 PMPM in allowed claims among members of non-tiered plans. See the databook.

[23] More information on the GIC can be found here. The Municipal Partnership Act in 2007 allowed Massachusetts cities and towns the option of obtaining health insurance for their employees and retirees through the GIC. Purchasing through the GIC was previously only available to state employees and retirees, retired teachers, and Springfield city employees and retirees.

[24] More information on the GIC's CPI Initiative can be found here.

[25] According to the GIC's 2012 CPII RFR Staff Recommendation (available via CommBuys), the CPII "relies on a database of over 126 million…claims aggregated from the six carriers currently providing health coverage to GIC members. The database is used to make quality and resource efficiency comparisons among providers. The health carriers then use the results of this analysis to design products that incorporate provider 'tiering', using modest co-pay differentials as incentives to encourage members to utilize more cost-efficient and high-quality providers." Further, according to The Commonwealth Fund's 2007 GIC profile, by July 1, 2007, all GIC health plans were "required to have some form of individual provider tiering incorporated into their GIC product, meaning that all GIC members who are not in a Medicare plan will not have a choice between a tiered or non-tiered product." Additional provider-tiering categories have been incorporated in the years since.

[26] CHIA's definition of tiered networks was based upon the Massachusetts Division of Insurance definition. See technical appendix for CHIA's full definition.

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